Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS DOCTOR'S PROFESSIONAL ASSN
2351 W NORTHWEST HIGHWAY SUITE 3100
DALLAS TX 75378

Carrier's Austin Representative Box
15

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Date Received
April 12, 2012

MFDR Tracking Number
M4-12-2608-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above dates of service have been returned due to reasons: '**Based on the findings of a review organization.'** Regarding the above dates of service, all procedures were pre-authorized under pre-auth. **#EIZR**. Enclosed is a copy of the pre-authorization letter and additional supporting documentation that states the above dates of service were authorized and billed correctly."

Amount in Dispute: $9,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has paid for each date of service in dispute pursuant to the fee guidelines set forth in DWC Rule (h)(1) and (5). Attached is a copy of the payment history showing payment plus interest was issued on 4/27/12…Respondent has paid Requestor $100 per hour for each hour billed. In conclusion, no additional reimbursement is owed to the Requestor as they have been paid pursuant to DWC Rule 134.204(h)."

Response Submitted by: Downs Stanford, PC, 2001 Bryan St., Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ $100.00)	$1,000.00	$0.00
September 13, 2011	Chronic Pain Management Program CPT Code 97799-CP (7 hours @ $100.00)	$875.00	$0.00
September 14, 2011	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours @ $100.00)	$937.50	$0.00
September 15, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ $100.00)	$1,000.00	$0.00
September 16, 2011	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours @ $100.00)	937.50	$0.00
September 19, 2011	Chronic Pain Management Program CPT Code 97799-CP (7 hours @ $100.00)	$875.00	$0.00

September 20, 2011	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours @ $100.00)	$937.50	$0.00
September 21, 2011	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours @ $100.00)	$937.50	$0.00
September 22, 2011	Chronic Pain Management Program CPT Code 97799-CP (7.5 hours @ $100.00)	$937.50	$0.00
September 23, 2011	Chronic Pain Management Program CPT Code 97799-CP (6.5 hours @ $100.00)	$812.50	$0.00
September 26, 2011	Chronic Pain Management Program CPT Code 97799-CP (2 hours @ $100.00)	$250.00	$0.00
TOTAL		$9,500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
4. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 20, 2011
   - 216 – Based on the findings of a review organization.

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the respondent denial reason code '216' supported?
3. Is the requestor the requestor entitled to reimbursement under 28 Texas Administrative Code §134.204?

Findings

1. Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated September 6, 2011 supports the Chronic Pain Management Program was approved for 80 hours under authorization number EIZR with a start date of August 31, 2011 and an end date of December 3, 2011 which includes the disputed services rendered September 12, 2011 through September 26, 2011.
2. 28 Texas Administrative Code, Section §133.240(b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of the title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated September 6, 2011 supports the provider obtained preauthorization for the disputed services of September 12, 2011 through September 26, 2011 for the

Chronic Pain Management Program x 80 hours under preauthorization number EIZR with a start date of August 31, 2011 and an end date of December 3, 2011, prior to providing the health care. The Division finds that the respondent's denial reason of "216" has not been supported. Therefore, the aforementioned services will be reviewed per the applicable Division rules and fee guidelines.

3. Per 28 Texas Administrative Code, Section §134.204(h)(5)(B), a chronic pain management program shall be reimbursed $125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. The requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. CPT code 97799-CP will be reimbursed at $100.00 per hour as follows:

   DOS September 12, 2011: $100.00 x 8 hours = $800.00

   DOS September 13, 2011: $100.00 x 7 hours = $700.00

   DOS September 14, 2011: $100.00 x 7.5 hours = $750.00

   DOS September 15, 2011: $100.00 x 8 hours = $800.00

   DOS September 16, 2011: $100.00 x 7.5 hours = $750.00

   DOS September 19, 2011: $100.00 x 7 hours = $700.00

   DOS September 20, 2011: $100.00 x 7.5 hours = $750.00

   DOS September 21, 2011: $100.00 x 7.5 hours = $750.00

   DOS September 22, 2011: $100.00 x 7.5 hours = $750.00

   DOS September 23, 2011: $100.00 x 6.5 hours = $650.00

   DOS September 26, 2011: $100.00 x 2 hours = $200.00

   The total maximum allowable reimbursement (MAR) is $7,600.00. The respondent previously paid $7,717.03, on April 27, 2012 under check number 274017. Therefore, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 11, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.